

**FORM E: FAMILY PLANNING PROGRAM FUNDING REQUEST & PROPOSED  
NUMBER OF UNDUPLICATED CLIENTS**

**Legal Business Name:**

**WOMEN'S HEALTH CARE CENTER, INC**

Family Planning Program contractors may seek reimbursement for project costs using the following methods:

- A. Contractors will be reimbursed using the Fee-For-Service reimbursement method by submitting claims to TMHP for direct clinical care services provided to Clients, which will then be paid by HHSC; and
- B. Contractors may seek cost reimbursement for services that enhance the Fee-For-Service services provided to Clients by submitting monthly vouchers for expenses detailed in the categorical budget attached to a contractor's contract.

**NOTE:** Applicants may request up to 100% of their total funding request to be reimbursed through the Fee-For-Service reimbursement method or Applicants may request a portion of their funding request to be reimbursed on a cost reimbursement basis in addition to the Fee-For-Service reimbursement method. However, the cost reimbursement amount requested may not exceed 50% of Applicant's total proposed funding request and ultimately, its funding award.

Enter the amount of funds requested in the boxes below:

Fee-for-Service Amount	300,000	
Cost Reimbursement Amount	0	
<b>Total Amount</b>	<b>300,000</b>	

The number of Unduplicated Clients an Applicant intends to serve through the Family Planning Program will be used to assess, in part, the Applicant's effectiveness in providing the proposed services under the contract resulting from this open enrollment. This number is the estimated total number of Unduplicated Clients to whom the Applicant will provide services at the proposed clinic sites. This total should be an estimate of the number of Unduplicated Clients the Applicant proposes to serve at the Family Planning Program clinic sites included in its application. Use the following average cost per Client OR submit an explanation of the average used by the agency: \$285.00.

Enter the estimated number of Unduplicated Clients to be served during the term of the contract, categorized by State Fiscal Year in the table below.

Period of Time	Proposed Number of Unduplicated Clients	
July 1, 2016 – August 31, 2016 – FY'16	100	
September 1, 2016 – August 31, 2017 -- FY'17	952	
<b>Total Number</b>	<b>1052</b>	

Applicants must provide an explanation/justification if the average cost per Client exceeds the statewide average of \$285.

## FORM I: FAMILY PLANNING PROGRAM CLINIC SITES

Legal Business Name: Women's Health Care Center, INC Clinic Site # 1 of 1

**CLINIC SITE INFORMATION:** Complete this form for EACH clinic site that will provide Family Planning Program services funded under this enrollment.

Clinic Name: Women's Health Care Center, INC			
Street Address: 2914 S Buckner			Suite: B
City: Dallas	County: Texas	Zip Code: 75227	HHSR: 3
Clinic APPOINTMENT Phone #: 214-275-5256			
Clinic PRIMARY Phone #: 214-275-5256		Fax: 214-275-5284	
Service Area (counties to be served by this clinic site):  Dallas			
Contact Person: Sherry Tenison			
Pharmacy License #:	Class:	Date of Pharmacy License Application Submission: 6-24-16	
TPI#:	156721606	NPI #:	1265462865
Date of Medicaid Application Submission(if no TPI# or NPI#):			
Subcontractor Site:		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Mobile Site:		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

## CLINIC HOURS

DAY	HOURS OF OPERATION					
	Morning		Afternoon		Evening (after 5pm)	
	From	To	From	To	From	To
MONDAY	9	1	2	5		
TUESDAY	9	1	2	5		
WEDNESDAY	9	1	2	5		
THURSDAY	9	1	2	5		
FRIDAY	9	1	2	5		
SATURDAY	9	12				
SUNDAY	Closed					

**Texas Health and Human Services Commission  
Vendor Information Form (VIF)**

Instructions: This form must be completed and submitted with each new contract, amendment, renewal, and/or extension.  
(Please type or print information.)

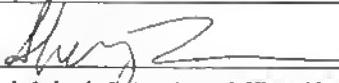
**SECTION 1: Contractor's General Information**

Legal Contractor's Name:	<u>Women's Health Care Center, Inc</u>		
Legal Doing Business As (DBA) Name:	<u>Women's Health Care Center, Inc</u>		
Physical Address:	<u>2914 S BUCKNER STE B DALLAS TEXAS 75227</u>		
Remit To (Payment) Address:	<u>2914 S BUCKNER STE B DALLAS TEXAS 75227</u>		
Enter Texas Identification Number (TIN)	Texas Identification Number (TIN): <u>-943432832</u> (11 digit TIN must be provided) <b>(Contact Accounts Payable at <a href="mailto:Vendor@hhsc.state.tx.us">Vendor@hhsc.state.tx.us</a> for valid 11 digit TIN (if unknown))</b>		
Select the Legal Status:	<input type="checkbox"/> For-profit Entity	<input checked="" type="checkbox"/> Non-profit Entity	
Select the Business Structure:	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Joint Venture	<input type="checkbox"/> Partnership*
	<input type="checkbox"/> Limited (Liability) Company	<input type="checkbox"/> Limited (Liability) Partnership	<input type="checkbox"/> Sole Proprietorship
	<input type="checkbox"/> Governmental Entity (must specify): _____		
	<input type="checkbox"/> Other (must specify): _____		
* If Partnership, must provide SSN or TIN for minimum of two partners			
Partner Name: _____	TIN : _____		
Partner Name: _____	TIN : _____		
If applicable, enter appropriate information:	State of Incorporation: <u>TEXAS</u>	Texas Charter Number: _____	Name of Parent Entity: _____

**SECTION 2: Contractor's Contact Information**

Person Who Will Sign the Contract		Point of Contact for Contract	
Name:	<u>SHERRY TENISON</u>	Name:	<u>SHERRY TENISON</u>
Title:	<u>EXECUTIVE OFFICE</u>	Title:	<u>EXECUTIVE DIRECTOR</u>
Mailing Address:	<u>2914 S BUCKNER</u>	Mailing Address:	<u>2914 S BUCKNER STE B</u>
Telephone:	<u>214-275-5256</u>	Telephone:	<u>214-275-5256</u>
Fax:	<u>214-275-5284</u>	Fax:	<u>214-275-5284</u>
E-mail:	<u>SHERTENISON@YAHOO.COM</u>	E-mail:	<u>SHERTENISON@YAHOO.COM</u>

**SECTION 3: Contractor's Authorized Signature (or HHSC Contract Manager)**

Printed Name	Signature	Date	Phone Number
<u>SHERRY TENISON</u>		<u>8/1/2016</u>	<u>214-703-6527</u>

**SECTION 4: ECPS Contract and Administration Office Use Only**

Contractor to Receive Payment: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
Contract Number:	

### **FORM A: FACE PAGE**

This form requests basic information about the Applicant and project, including the signature of the authorized representative.  
The face page must be completed in its entirety.

#### **APPLICANT INFORMATION**

1) <b>LEGAL BUSINESS NAME:</b> WOMEN'S HEALTH CARE CENTER, INC.				
2) <b>MAILING Address Information</b> (include mailing address, street, city, county, state and zip code) 2914 S BUCKNER STE B DALLAS TEXAS 75227				
3) <b>PAYEE Name and Mailing Address</b> (if different from above):				
4) <b>DUNS Number</b> (9-digit): 829195259	5) <b>Health and Human Service Region:</b>			
6) <b>Federal Tax ID No.</b> (9 digit), <b>State of Texas Comptroller Vendor ID No.</b> (14 digit) or <b>Social Security Number</b> (9 digit):			943432832	
<p><i>*The Applicant acknowledges, understands and agrees that the Applicant's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.</i></p>				
7) <b>TYPE OF ENTITY</b> (check all that apply):				
<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> Other Political Subdivision <input type="checkbox"/> State Agency <input type="checkbox"/> Indian Tribe	<input checked="" type="checkbox"/> Nonprofit Organization* <input type="checkbox"/> For Profit Organization* <input type="checkbox"/> HU8 Certified <input type="checkbox"/> Community-Based Organization <input type="checkbox"/> Minority Organization <input type="checkbox"/> Faith Based (Nonprofit Org)	<input type="checkbox"/> Individual <input type="checkbox"/> Federally Qualified Health Centers <input type="checkbox"/> State Controlled Institution of Higher Learning <input type="checkbox"/> Hospital <input type="checkbox"/> Private <input type="checkbox"/> Other (specify): _____		
<small>*If incorporated, provide 10-digit charter number assigned by Secretary of State: 0800987809</small>				
8) <b>BUDGET PERIOD:</b>	Start Date: July 1, 2016	End Date:	August 31, 2017	
9) <b>COUNTIES SERVED BY FAMILY PLANNING PROJECT:</b> (complete Form C-Texas Counties and Regions) DALLAS				
10) <b>PRIMARY PLACE OF SERVICES PROVIDED</b> 2914 S BUCKNER STE B DALLAS TEXAS 75227				
11) <b>TOTAL FUNDING REQUESTED:</b> 300,000	13) <b>FAMILY PLANNING (FP) PRIMARY CONTACT PERSON</b> Name: SHERRY TENISON RN, EXECUTIVE DIRECTOR Phone: 214-275-5256 Fax: 214-275-5284 Email:SHERRYTENISON@YAHOO.COM			
Fee for Service: \$300,000	Categorical: 0			
12) <b>PROJECTED EXPENDITURES</b> Does Applicant's projected federal expenditures exceed \$500,000, or its projected state expenditures exceed \$500,000, for Applicant's current fiscal year (excluding amount requested in line 9 above)? **				14) <b>FINANCIAL OFFICER</b> Name: Donnie Graham Phone 214 Fax:214- 275- 5284 Email:Do nnie Graham @
<small>**Projected expenditures should include anticipated expenditures under all federal grants including "pass through" federal funds from all state agencies, or all anticipated expenditures under state grants, as applicable.</small>				

The facts affirmed by me in this proposal are truthful and I warrant the Applicant is in compliance with the assurances and certifications contained in **APPENDIX I: HHSC Assurances and Certifications**. I understand the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. This document has been duly authorized by the governing body of the Applicant and I (the person signing below) am authorized to represent the Applicant.

15) <b>AUTHORIZED REPRESENTATIVE</b>	16) <b>SIGNATURE OF AUTHORIZED REPRESENTATIVE</b>
Name: Sherry Tenison RN Executive Director Title: Executive Director	 17) DATE 8/1/2016

**Family Planning Program**  
529-16-0102

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Phone: 214-275-5256  
Fax: 214-275-5284  
Email: [sherrutepinson@yahoo.com](mailto:sherrutepinson@yahoo.com)

8-1-2016